MACRA, Fraud, and the Winds of Change for Podiatry

When it comes to billing and coding, forewarned is forearmed.

BY JOSEPH BORREGGINE, DPM

With the Affordable Care Act, the rigors of MACRA, the new Merit Incentive Payment System (MIPS), and the Alternative Payment Models (ADM), podiatrists are going to have to identify how practice will change in the next few years. With the escalating costs that have burdened Medicare since its inception, CMS has instituted a Medicare Fraud Strike Force to recoup all the monies that were considered paid to providers who allegedly committed fraud. Currently, CMS has collected over $8.9 billion in their efforts to collect the revenues paid to over 2,900 providers who billed Medicare fraudulently.

CMS Will Not Stop

The Medicare Fraud Strike Force has been dedicated since 2007 to catching providers committing Medicare fraud; and since the podiatric profession annually generates $800 million in collected revenues paid by Medicare for "routine foot care", CMS routinely likes to target the podiatric profession. In June 2016, a podiatrist in Pennsylvania along with 61 other physicians (of different specialties) was caught up in a sting that was the largest fraud and abuse case on record with the U.S. Department of Justice. This fraud case totaled $900 million in fraudulent billings. The podiatrist alone from 2007-2015 generated $5 million of that amount.

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As of June 2016, CMS also finalized the "Medicare Overpayment Rule" whereby the Medicare providers have sixty days to identify any "overpayment" made to them. As part of the Affordable Care Act that passed in 2010, the Department of Health and Human Services (HHS), Office of Inspector General (OIG) was charged with implementing the provision and an eventual final rule which states:

"Under Section 6402(d)(2)(A)(iii) of the ACA,2 healthcare providers must report and return overpayments within 60 days after identifying the overpayments or by the date on which a corresponding cost report is due. In notifying the party to whom the repayment will be made, the provider must also explain the reason for the overpayment. A failure to refund an overpayment by the requisite deadline will expose the provider to enforcement under the False Claims Act.3 Furthermore, under Section 6408(a) of the ACA, 4 providers who do not report and repay an identified overpayment will be subject to significant civil monetary penalties. Overpayments from Medicare or Medicaid can arise in a number of forms (e.g., payments for non-covered services, payments in excess of the allowable amount for an identified covered service, duplicate payments, payments where another payer has the primary responsibility for the payment)".

The "overpayment" must be paid back once "identified", but what is the "standard" to which CMS will hold

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providers accountable to do so? CMS states the following: *"The standard that CMS is using for knowledge is not "actual knowledge," but instead is when the provider would have identified the overpayment, had it exercised a reasonable level of diligence. This standard is known as the "reasonable diligence" standard, and comes into play, as noted above, once a person has "identified an overpayment when the person has or should have, through the exercise of reasonable diligence, determined both that the person has received an overpayment and quantified the amount of the overpayment."*

And CMS has a "Look-Back Rule": *"The 60 Day Rule also provides for a look-back period of six years, instead of the ten years CMS had originally put in its 2012 proposed rulemaking. This means that CMS can review six years of claims for any additional overpayments on top of the original overpayment identified by the provider or supplier."*

The fines for not adhering to this new rule that CMS looks to levy on uncooperative providers—once the rule is final—could vary from $5,000-$10,000 per claim that is considered an "overpayment".

So, how does a podiatrist fare in this new environment that CMS and Medicare have created to save money and save the program from fiscal ruin and insolvency? Remember, "The best defense is to have a good offense." Prevention is the key to help one navigate through this minefield of "fraud and abuse" potential. The podiatrist must understand and be very knowledgeable about all the Local Carrier Determinations (LCDs) provided by the assigned Medicare Administrative Contractor (MAC). Knowing where to find these LCDs on the CMS website is essential to success in not billing a Medicare claim in error. Here is the URL reference link on Medicare LCDs: http://tinyurl.com/jnwm784.

Podiatrists must comprehend that they are considered "fertile hunting grounds" and therefore must do everything they can to stay out of the CMS gun sights. However, even when thinking one is practicing within the lines, there are shades that look grey to a podiatrist but that look black and white to an auditor incentivized to recoup cash from a doctor who cannot afford to dissent and fight on principle. This is a "no win scenario" and if you think otherwise, then it will be rather costly to prove it to the contrary. So the best way to stay within those "lines" is by practicing good medicine using the LCDs.

Some physicians are ignorant of the potential penalties that they could face if they do not do everything in their power to rectify their mistakes.

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Comparative Billing Reports

CMS recently has been providing Medicare providers with "Comparative Billing Reports" (CBR) that are meant to educate physicians on their "incorrect billing practices" and provide data that allow providers to understand how they compare to their peers of the same specialty based on certain billing scenarios.

Podiatrists have been targeted with respect to billing: *Evaluation and Management" CPT codes (99211-99215) with nail debridement CPT codes: 11720 or 11721. A June 2002 Office of Inspector General (OIG) report demonstrated the following, "Medicare allowed $51.2 million in improper payments for nail debridement services…and since these payments were inappropriate so were the services rendered along with nail debridement, hence another $45.6 million and was deemed improper as well… the total for all improper payments were $96.8 million".*

In the First Quarter of the Fiscal Year 2016, CMS has determined billing error rates of 56.1% for CPT code 11720 and 47.6% for CPT code 11721. Most of the errors were related to lack of proper documentation or illegibility. This investigation also discovered a *"…claims error rate for July 2015 through December 2015 from 80.3-88.75% based on E/M services which were not eligible for reimbursement because they were directly related to the nail debridement services, and no other problems were identified in the medical record".*

The CBR provides the tenets to "Coverage and Documentation Overview" regarding nail debridement services and how this report is generated to help the provider understand the "error of their ways". The CBR is a "warning shot across the bow" of podiatrists' practices and billing habits that need to immediately change. This means that The CBR is watching and will continue to do so until the abnormal percentages for the codes in question drop to the proper level or disappear completely. If not, a full-blown Medicare audit most likely will ensue. So it is imperative to fully read the CBR, and review the statistics presented as compared to your peers, and do the due diligence necessary to correct the impropriety.

This information from CMS may be rather disheartening and rather hard to swallow, process, and digest, but this is the way things are and will continue to be. Regardless of what has been concluded from the investigation, this truly is a distraction from the real issue of practicing day-to-day podiatry. Since Medicare has deemed "routine foot care" a potentially covered service, most podiatrists take full advantage of this policy; hence otherwise honest people commit possible fraud in the process of taking care of patients and staying in business. The findings in the CBR have concluded that this profession may be providing "routine foot care" in a manner that may not be completely above-board.

Most podiatrists do not share the same assumption provided in the CBR report re: "routine foot care" billing unless they have received a dreaded letter from CMS stating the contrary. Podiatrists nationwide continue to play a ridiculous balancing game with the CMS Medicare LCD L34246, trying to help patients with questionably

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covered painful corns and calluses, fungus, and dystrophic toenails.

Routine Foot Care

With the amount of money that Medicare pays to this profession, it would seem that every person on Medicare can somehow qualify for "routine foot care". According to CMS, *"…nail debridement is by far the single largest paid service, accounting for almost one-fourth of all the Medicare payments to podiatrists."*

The fact is that "being honest" in one's routine foot care billing may be equal to having to accept a loss of a number of patients who will find someone more willing to risk their license and livelihood. The reason this is true is that most Medicare beneficiaries are not used to paying for any service. They ignorantly believe that Medicare and their co-insurance (if they have one) should pay for all their medical services, and they should owe nothing. This "entitlement mentality" causes most physicians not to disagree, debate or argue with their patients on this issue. Therefore, the Medicare program has gone unfettered for the last 50 years when it comes to paying physicians. Now with MACRA on the horizon, it looks like things of old are going to come to a screeching halt.

Statistically, annual podiatric incomes are rather comfortable and provide a decent living. Since podiatrists treat a large number of patients via Medicare, a large percentage of that annual income is derived from routine foot care. But some podiatric practices may not provide this type of care to their Medicare patients. They do so because of the arduous Medicare LCD policy which limits the number of patients who actually qualify.

Other Revenue Streams

Since this may be the case, the podiatrist may need to consider bolstering other revenue streams that are also included as covered services in the Medicare program. These may include increasing surgical procedures, diagnostic ultrasound-guided needle placement, wound care, DME (diabetic shoes and Rx AFOs); but just like routine foot care all of these procedures have their associated LCDs and eventually CMS will catch up to those who abuse the system.

To combat this problem, the Affordable Care Act in 2015 created greater transparency for the public and has provided payment data in great detail so that anyone can see 1) what a doctor has been paid on an annual basis, and 2) the actual amount and the number of times that a particular procedure was billed for during that year. This information can be accessed directly on line. One site is available on the CMS website: http://tinyurl.com/z7o4fru, and the other can be found on the *Wall Street Journal* website: http://tinyurl.com/hk5sbld

CMS provides a detailed report not only for the public but other medical colleagues as well. Practitioners can compare themselves geographically to their professional peers and see what they are being paid by Medicare. This information can be viewed in a manner that can create unnecessary prejudice in the public eye, but also can cause dissent between professionals in the same specialty. This was a good idea on the behalf of CMS and the federal government, but in the long run, what does it really do to provide a true picture about a physician who is a Medicare provider?

Ongoing Scrutiny

So where does this leave us? With the impending changes of MACRA, along with the continued use of PQRS, VBMs, and EHR, the practicing physician does not have many options left to make a living without the scrutiny of government policy looming overhead at every turn. This matter is just the tip of the iceberg because Medicare has created a treacherous environment and other payers will eventually follow suit. With ACA firmly in place (well, at least for the moment), insurers enjoy high deductibles and leave doctors to struggle to collect their fees. As time continues, payers will lower their reimbursements to doctors and raise patients' premiums. Eventually, Medicare will become the highest-paying insurance company to physicians.

What is the answer? CMS and the federal government believe that MACRA is the answer to over-utilization, fraud, and abuse, and will maintain the fiscal life of the Medicare program. The other government policies that have burdened physicians, like HIPAA, ICD-10, and the advent of ACOs, continue to contribute to an environment in which medical professionals feel more than ever that they are being forced to kowtow to the whims and will of those in charge.

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Yes, there is a problem and CMS is doing everything in their power to try to fix it, but it may be a bit too late. The trillions of dollars owed to the Medicare program since its inception is unfathomable.

But there may be a silver lining in all of this. A single payer system—one payer that has one set of rules and pays the same to everyone—may already be in the works and can possibly solve this government-made crisis. There may even be a loan forgiveness package built in for those physicians who decide to fully vest themselves in this program. Such as system may eventually be the replacement for MACRA, and if implemented would certainly be a change for the better. **PM**

Dr. Borreggine has been in practice for over twenty-five years and has been avidly involved in Illinois' podiatric leadership for many of those years. He served as Illinois' president in 2009 and now participates as their Healthcare Advisory Committee Chair along with serving on the newly formed APMA carrier advisory committee for DME issues.